

Health,
Welfare
Public
Service

THE DIVISION OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

59-007534

STATE FILE NUMBER

Registration District No. 1093

Registration District No. Primary Registration District No. Registrar No. 1093

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| 1. PLACE OF DEATH a. COUNTY | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MISSOURI b. COUNTY | |
| b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN ST. Louis | | c. CITY OR TOWN ST. Louis | |
| Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | | Inside Limits Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> | |
| c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION LUTHERAN HOSPITAL | | d. STREET ADDRESS (If outside, give location) 3327 OREGON | |
| Length of stay in lb | | Reside on Farm Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> | |

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| 3. NAME OF DECEASED (Type or print) First Middle Last ANNA PETERS | | | 4. DATE OF DEATH Month Day Year JAN 30 1959 | | |
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| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH JULY 26 1887 | 9. AGE (In years last birthday) 71 | IF UNDER 1 YEAR Months Days Hours Min. | IF UNDER 24 HRS. |
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| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSE WIFE | 10b. KIND OF BUSINESS OR INDUSTRY | 11. BIRTHPLACE (City and state or country) AUSTRIA | 12. CITIZEN OF WHAT COUNTRY? U-S-A |
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| 13a. FATHER'S NAME UNKNOWN TEZAK | 13b. MOTHER'S MAIDEN NAME UNKNOWN | 14. NAME OF HUSBAND OR WIFE JOSEPH PETERS |
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| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) NO | 16. SOCIAL SECURITY NO. NONE | 17. INFORMANT Address JOSEPH PETERS 3327 OREGON |
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| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary Embolism | | INTERVAL BETWEEN ONSET AND DEATH |
| DUE TO (b) Fracture of left Pelvis. | | |
| DUE TO (c) | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not included in the immediate cause (a) or (b) or (c) above. Admitted when struck by auto operated by one Oregon State at intersection of Oregon and Arsenal Streets about 7:25 am., December 10th 1958. | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |

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| 20a. ACCIDENT <input checked="" type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/> | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter name of injury in PART I or PART II, item 18.) Struck while at intersection of Oregon and Arsenal Streets about 7:25 am., December 10th 1958. | |
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| 20c. TIME OF INJURY Hour Month, Day, Year 7:26 a.m. 12 10 58 1958. | 20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office, bldg., etc.) 240 Street | 20f. CITY, TOWN, OR LOCATION COUNTY STATE St Louis MO |
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| 21. I attended the deceased from _____ to _____ and last saw her alive on _____ Death occurred at 6:30 a.m. on the date stated above; and to the best of my knowledge, from the causes stated. |
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| 22a. SIGNATURE (Degree or title) Patrick J. Taylor Carver | 22b. ADDRESS 1300 Clark | 22c. DATE SIGNED 1.30.59. |
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| 23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL | 23b. DATE FEB 2 1959 | 23c. NAME OF CEMETERY OR CREMATORY RESURRECTION SEM. | 23d. LOCATION (City, town, or county) (State) ST. LOUIS MO |
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| 24. FUNERAL DIRECTOR ADDRESS Thomas Kutis 2906 Gravois | 25. DATE RECD. BY LOCAL REG. JAN 30 '59 | 26. REGISTRAR'S SIGNATURE Earl Smith. M.D. |
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USE ONLY BLACK INK OR RIBBON TYPEWRITE IF POSSIBLE

All diseases in Part I must be causally related.

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16
2492
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STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by _____, Student Embalmer No. _____ working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed E. Luantjovine _____

Licensed Embalmer No. _____

P. O. Address _____

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.